Ryan White Part A Program Central CAREWare Policies & Procedures Including Central Eligibility and Referrals

Table of Contents

General Data Entry Policies	4
Client Demographic Tab	4
Key Fields	5
Name Fields	5
Date of Birth	5
Gender	5
Client URN and Encrypted URN	5
Encrypted UCI	6
Ethnicity/Race	6
Client ID	7
Address Fields	7
Zip code Field	8
County	8
Phone Number	8
Memo Field	8
HIV Status and Diagnosis Dates	8
HIV Risk Factor	9
Service Tab	10
Year	
Vital Status	10
Deceased Date	10
Enroll Status	11
Enroll Date	
Case Closed Date	
Annual Tab	
Primary Source of Medical Insurance	12
Other Sources of Medical Insurance	
Primary HIV Medical Care	
Annual Household Income/Size	
Housing/Living Arrangement	
Service Entry	
Entering Services	
Direct Client Service	
Cost Reimbursement and/or Anonymous Client Service	
Service Entry Considerations	
Group Rapid Service Entry	
Financial Report	
Financial Report Notes	
Referrals	
Central Eligibility Tab	
Centralized Eligibility	24

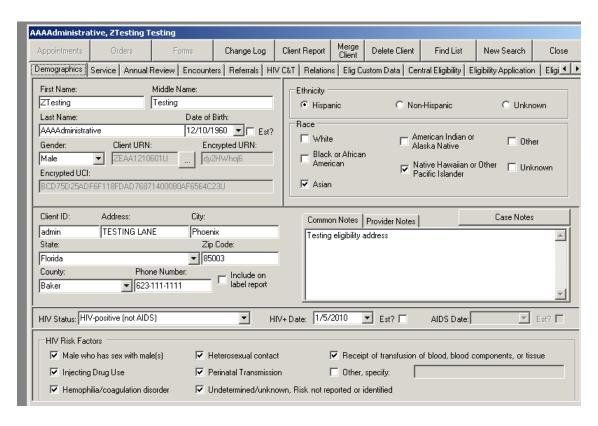
Client Eligibility Status Verification	24
Provider Data Collection.	
Ryan White Part A Status Updates	25
CE Eligibility Status	
CE Income Level	27
CE HIV Doc Received	27
CE Inc/Res Due	27
CE Documentation	28
CE Provider Received	28
CE Comments	28
CE RW Dental Enroll Status	28
CE FAP Fields	28
Form Data Entry Requirements	29
Form/Service Entry Best Practices	29
AHCCCS Applications	29
Eligibility Status How to Tell	29
Custom Eligibility Application Fields	30
Ryan White Program Data Report (RDR)	31
Who Completes the Ryan White HIV/AIDS Program Annual Data Report?	
Which Clients Should be Included in the RDR Report?	31
Ryan White Program Services Report (RSR)	33
Who Completes the Service Provider Report?	33
Who Completes the Client Report?	33
Clinical Data Entry for Bi-Annual Data Report	
Entering Clinical Encounter Data	34
Create Encounter	
Vital Signs	35
Hospital/ER Admissions	36
Medications	36
Labs	40
Screening Labs	41
Screenings	42
Immunizations	43
Diagnoses	44
Case Notes	
Special Instructions	
Miscellaneous	46
Seeking Assistance	46
Permission Descriptions	
GLOSSARY OF RYAN WHITE HIV/AIDS PROGRAM DATA REPORT TERMS	47

The following information has been outlined to identify for any centralized CAREWare users within the Phoenix EMA the policies and procedures to be used for entering data within the system. It is fully understood that the various fields affect the ability for each provider to communicate properly with clients, to have the ability to maintain an unduplicated client database, to produce the HIV/AIDS Ryan White Data Report (RDR) and the Ryan White Service Report (RSR) and to allow the Part A Office to provide aggregated reporting necessary for Grant Management and for the Planning Council. In addition, the data that is entered must comply with standard definitions by either HRSA, state authorities, grantee contracts and policies and procedures. Definitions and information that are available from a HRSA and/or a grantee based policy document will be incorporated into this document.

General Data Entry Policies

- 1. Capitalization All fields are to be entered in an upper/lower case format. The first initial of formal names are to be capitalized unless another format is deemed necessary.
- 2. Unknown/Unreported Never change known info to unknown/unreported if valid data exists
- 3. If you see valid data along with unknown data, please remove the unknown data

Client Demographic Tab



Key Fields

The primary fields used to produce an unduplicated client database within CAREWare are: First name, Last Name, Date of Birth and Gender.

Name Fields

The client's formal name is to be entered in the first, middle and last name fields. Notes:

- Spelling of the name is to follow the legal format
 - o Ex, TeKampe (capitalization of other letters)
 - o Ex, O'Connor (use the appropriate capitalization and use of characters)
 - o Ex, De La Cruz (use appropriate spacing of name as well)
- Seek clarity of names by verifying with an ID or legal documents
- The critical fields are the first and last name
- Nicknames/aliases are to be placed in the memo field, see memo field instructions

Date of Birth

The client's true date of birth, record it from an id card if needed for verification. Notes:

- The use of estimated birthdates is not allowed
- If you do not have the birth date you will not be able to enter the client into CAREWare

Gender

The client's self reported gender they identify as.

Notes:

- This is a self reported field
- Unknowns are unacceptable, Must have this information

2009 Instructions for the Ryan White HIV/AIDS Program Data Report - Page 13

25. Gender of clients

Report the actual unduplicated numbers of male, female, and transgender clients (this item should be based on the self-report of the client), and the number of clients for whom gender is unknown or unreported. Include infants under the age of 2 whose HIV status is indeterminate in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

Transgender is an individual whose gender identity is not congruent with his or her biological gender, regardless of the status of surgical and hormonal gender reassignment processes. Sometimes the term is used as an umbrella term encompassing transsexuals, transvestites, crossdressers, and others. The term transgender refers to a continuum of gender expressions, identities, and roles, which expand the current dominant cultural values of what it means to be male or female.

Client URN and Encrypted URN

These are calculated fields and the URN can be modified to accommodate multiple clients with the same URN and the encrypted URN is an encrypted value for the URN. Notes:

- First and Third Initials of First name
- First and Third Initials of Last name
- Date of Birth
- Gender 1 = male, 2=female, 3=transgender, 9=unknown/unreported
- Unique character

Encrypted UCI

This is a calculated field used for the Ryan White Program Service client level report.

Ethnicity/Race

Indicate if the client is Hispanic or not and then indicate what race(s) the client identifies themselves as Notes:

- This is a required field, unknown/unreported is not valid
- This is a self report field
- If a client is marked as Hispanic, you do not need to check a race field
- A client that has an unknown Ethnicity and no Race checked will report as unknown/unreported

2009 Instructions for the Ryan White HIV/AIDS Program Data Report Page 13-14

27. Race/Ethnicity of clients

Based on the client's self-report, report the number of unduplicated clients by race and ethnicity, Hispanic (27a) or non-Hispanic (27b).

If clients report race, but not ethnicity, report them in the appropriate race category in the non-Hispanic table (27b). Similarly, if clients report their ethnicity as Hispanic, but do not report race, report them in the "Not reported" race category in the Hispanic table (27a). Clients who report neither race nor ethnicity should be included in the "Not reported" race category and in the non-Hispanic table (27b). Do not include any anonymous clients in these counts. All clients who identify with more than one race should be included in the "More than one race" category and in either the Hispanic (27a) or non-Hispanic (27b) table.

2009 Instructions for the Ryan White HIV/AIDS Program Data Report 13

The following racial category descriptions, defined in October 1997, are required for all Federal reporting, as mandated by the Office of Management and Budget. For more information go to:

http://www.whitehouse.gov/omb/fedreg/1997standards.html).

Race and ethnicity categories:

American Indian or Alaska Native is an individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian is an individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American is an individual having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander is an individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White is an individual having origins in any of the original peoples of Europe, the Middle East, or North Africa.

More than one race is an individual who identifies with more than one race.

Not reported is an individual who did not self-report either race or ethnicity.

Hispanic (or Latino) is an individual of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

a. Hispanic clients

Report the number of unduplicated Hispanic clients by race.

b. Non-Hispanic clients

Report the number of unduplicated non-Hispanic clients by race.

HRSA CAREWare User Manual 7/16/2006

For HRSA CADR reporting purposes, Race/Ethnicity needs to be entered for each client. This is self-selected by clients, and your intake forms should reflect these categories.

Many Hispanic clients self-select Hispanic as their ethnicity and do not specify a race. <u>CAREWare will no longer consider this as missing data for CADR purposes</u>. However, if a non-Hispanic client's race is not specified, it *will* be considered missing data for that individual.

Client ID

Not Shared

This is a provider specific field that is used to identify clients between multiple systems. Each agency will determine the use of this field.

Address Fields

Address, City, State, Zip, Include on Label Report

These fields indicate the client's mailing address. The data is to be entered following the USPS guidelines for bulk mail.

Notes:

- If a client has a different eligibility address you will need to record the eligibility address in the memo field, see memo field instructions
- State Field is a drop down list, which is used to build the County Field
- If the client homeless and does not have a mailing address, enter Homeless in the street address line
- Include on Label Report

- Will allow you from within CAREWare to run the mailing labels report
- Is not shared

Zip code Field

Due to the new Ryan White Services Report this field is required to be entered even for clients who are considered homeless. Please use either the guidelines above for Address fields and/or enter a zip code that is in the area the client's eligibility has been determined, even if homeless.

County

This field indicates the county in which their eligibility address is. Notes:

- If the client's mailing address and eligibility addresses calculate different County's use the county that matches the eligibility address
- This is not a mailing address field, this is an eligibility field

Phone Number

This field contains the primary phone number the client has provided to be contacted on. There are additional custom fields that indicate if leaving messages are ok and an additional phone number. These fields are found on the client Information Form.

Memo Field

This field is to be used only for showing a client's aka/aliases and/or eligibility address information Notes:

- Recording AKA/Aliases/Nicknames
 - o Click into the Memo Field and go to the beginning of the field
 - Type AKA:
 - Immediately following AKA: enter the additional names the client goes by
- Recording Eligibility Address Information
 - Click into the Memo Field and go to the area below the AKA info (if applicable, otherwise you would start at the beginning of the field)
 - Type Eligibility Address:
 - On the next line enter the street address
 - On the next line enter the City State Zip
 - o If a client is homeless with a mailing address, indicate in the memo field as homeless
- This is the format for this field
- Any additional information will need to be stored in the Case Notes or in custom fields
- New Eligibility Application custom fields are found on the Client Information Form

HIV Status and Diagnosis Dates

This field is to indicate the current HIV Status of a client and the date(s) that the client was originally diagnosed with the either HIV or AIDS Notes:

- Once a client has been diagnosed as AIDS, they must be reported as AIDS
 - o The status may change from HIV to AIDS
 - o The status can not change from AIDS back to HIV

- The Date fields will become active depending on the HIV Status that is selected
 - o Using an estimated date here is fine
 - o Be sure to ask the client for the earliest date they were diagnosed

2009 Instructions for the Ryan White HIV/AIDS Program Data Report Page 16

31. HIV/AIDS status

Report the total number of clients by their HIV/AIDS status at the end of the reporting period.

- HIV-positive, not AIDS clients have tested positive for and been diagnosed with HIV, but have not advanced to AIDS.
- *HIV-positive, AIDS status unknown* clients have tested positive for and been diagnosed with HIV. It is unknown whether or not the client has advanced to AIDS.
- CDC-defined AIDS clients are HIV-infected individuals who meets the CDC AIDS case definition for an adult or child.
- HIV-indeterminate (infants only) clients are children under age 2 whose HIV status is not yet determined but was born to an HIV-infected mother.
 - *HIV-negative (affected)* clients have tested negative for HIV; are an affected partner or family member of an individual who is HIV-positive; and have received at least one RWHAP-funded support service during the reporting period.
 - *Unknown (affected)* indicates a client who is not an infant and whose HIV/AIDS status is unknown or was not reported.

NOTE: Once a client has been diagnosed with AIDS, he or she is always counted in the CDC-defined AIDS category regardless of changes in CD4 counts. For additional information, see: http://www.cdc.gov/ncphi/disss/nndss/casedef/aidscurrent.htm.

HIV Risk Factor

This field is to indicate the factor that places the client at risk for disease.

Notes:

- Based upon client's self report
- This is a required field
- Check all that apply

2009 Instructions for the Ryan White HIV/AIDS Program Data Report Page 23

44. HIV exposure category

Report the number of unduplicated clients in each of the HIV exposure categories.

Clients with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for males with a history of both sex with men and injection drug use. They are counted in a separate category.

Men who have sex with men (MSM) cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). Injection drug user (IDU) cases include clients who report use of drugs intravenously or through skin-popping.

MSM and IDU cases include men who report sexual contact with men and use of drugs intravenously or through skin-popping.

Hemophilia/coagulation disorder cases include clients with delayed clotting of the blood.

Heterosexual contact cases include clients who report specific heterosexual contact with an individual with, or at increased risk for, HIV infection (e.g., an injection drug user).

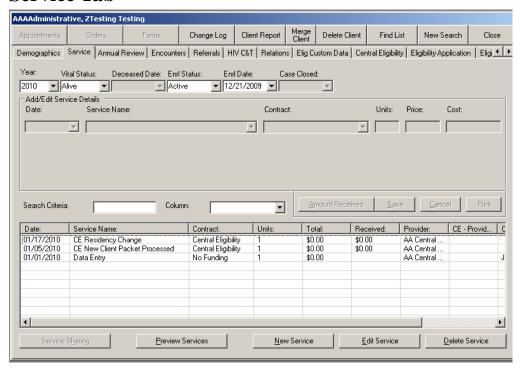
Receipt of transfusion of blood, blood components, or tissue cases include transmission through receipt of infected blood or tissue products given for medical care.

Mother with/at risk for HIV infection (perinatal transmission) cases include transmission from mother to child during pregnancy. This category is exclusively for infants and children infected by mothers who are HIV-positive or at risk.

Other indicates the client's exposure category is known, but not listed above.

Undetermined/unknown, risk not reported or identified indicates the client's exposure category is unknown or not reported for data collection.

Service Tab



Year

This drop down list selects the year in which you are looking to review and/or enter data for. By default the system will use the current system date as the year that initially shows.

Vital Status

This field indicates if the client is alive/deceased/unknown Notes:

- Should be used to indicate alive or deceased
- Unknown should not be used
- Please use this field carefully as the client will show up as deceased on all providers.

Deceased Date

This field indicates the date a client was deceased.

Notes:

• Enter the best date you know of the client's death

Enroll Status

Not Shared

This field indicates the client's status within a provider Notes:

- Choices are
 - Active
 - o Inactive/Case Closed
 - o Unknown
- This field is used on both the RDR and RSR reporting to determine if a client is new and/or
 continuing in the program. The client should be marked as Inactive/Case Closed if the client
 does not receive any services from the provider due to lost to follow up, case closed and no
 services will be provided due to client moving etc. This should not be used for internal processes
 or definitions.

Enroll Date

Not Shared

This field indicates the date a client was first enrolled with this provider Notes:

- This should reflect the 1st date a client was seen by this provider
- No services can be entered before this date

2009 Instructions for the Ryan White HIV/AIDS Program Data Report Page 23

32. Vital/enrollment status categories

Report the number of clients with each vital/enrollment status at the end of the reporting period.

Active client, new to the program is an individual whose first point of contact with the program occurred during this reporting period.

Active client, continuing in program is an individual who was a client when the period started and continued in the program.

Deceased clients have died sometime during this reporting period.

Inactive includes, for example, clients who have moved or were lost to follow-up.

Unknown/unreported indicates that the vital/enrollment status is unknown or not reported.

Case Closed Date

Not Shared

This field indicates the date a client was closed with this provider Notes:

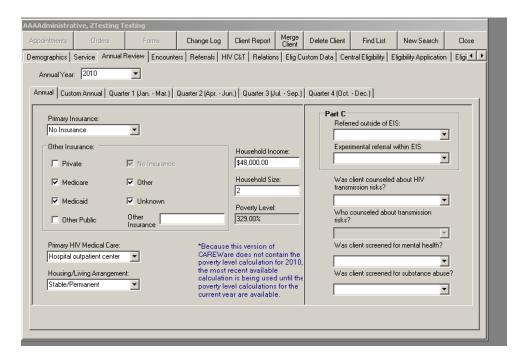
• This will disable you from entering services past the date entered

HRSA CAREWare User Manual 7/16/2006

Services may be entered after a <u>deceased</u> date (for example, when some case management is performed) but not after a <u>case closed</u> date and not before the enrollment date

Annual Tab

In order to view the annual tab you must have at least one service entry posted for the year you want to view.



Primary Source of Medical Insurance

This field is to indicate what the client's primary source is for medical Insurance. Notes:

- Medical Providers this is based upon Third Party Reimbursements
 - This should be the primary insurance at the end of the reporting period or the most recent data available
 - Other providers, based upon client's self report
- This is a required field

Other Sources of Medical Insurance

This field is to indicate all of the medical Insurances the client had available for funding during the calendar year. This field will update automatically as the primary insurance field is changed. Ie, the client initially has no insurance and then begins to receive Medicaid 5 months later. The primary source of insurance field is updated with the new Medicaid as primary and this field will reflect No insurance. Notes: Updating of this field should occur automatically as the client changes available insurance programs.

 $2009\ Instructions$ for the Ryan White HIV/AIDS Program Data Report Page 15-16

30. Primary source of medical insurance

Report the number of clients receiving each type of medical insurance at the end of the reporting period, or the most recent data available for the reporting period.

Select only one form of insurance for each client. Report the medical insurance that provides the most reimbursement if a client has more than one source of insurance at the end of the reporting period. If a client's only means of covering the costs of services is Ryan White HIV/AIDS Program funds, report the client in the "no insurance" category. Include infants under the age of 2 whose HIV status is indeterminate in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

Private includes health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, and Aetna.
Medicare is a health insurance program for people ages 65 years and older, people with disabilities under age 65, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).
Medicaid is a jointly funded, Federal-State health insurance program for people with low incomes.
Other public includes other Federal, State, and/or local government programs providing a broad set of benefits for eligible individuals. Examples include State-funded insurance plans, military health care (Tricare), State Children's Insurance Program (SCHIP), Indian Health Services, and Veterans Health Administration.

No insurance indicates that the client did not have insurance to cover the cost of services at any time during the reporting period, the client self-pays, or services are covered by RWHAP funds.

Other indicates that the client has an insurance type other than those listed above.

Unknown/unreported indicates that the primary source of medical insurance is unknown and not documented.

Primary HIV Medical Care

This field is to indicate what the client's primary method is for Primary HIV Medical Care Notes:

- Medical Providers this is based what your institution is categorized as
 - o Other providers, based upon client's self report
- This is a required field

Annual Household Income/Size

These fields are used for poverty level calculations Notes:

- These fields are to be based upon income eligibility documents received at intake and recertification
- These are required fields

2009 Instructions for the Ryan White HIV/AIDS Program Data Report Page 15-16

28. Annual household income

Report the annual household income category of the client **at the end of the reporting period**, or report the most recent data available within the reporting period. Income is defined in ranges relative to the Federal poverty guidelines. Include infants under the age of 2, whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

Household includes all people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of related or unrelated people who **share** living arrangements.

Household income is the sum of money received in the previous calendar year by all household members, ages 15 years and older, including household members not related to the householder and people living alone.

Families and individuals are classified as below poverty level if their total family income or <u>unrelated individual income</u> was less than the poverty threshold specified for the applicable family size, age of householder, and number of related children under 18 present. Poverty status is determined for all families (and, by implication, all family members).

For individuals not in families, poverty status is determined by their income in relation to the appropriate poverty threshold. Thus, two unrelated individuals living together may not have the same poverty status. The poverty thresholds are updated each year to reflect changes in the Consumer Price Index. See Poverty Guidelines, Research, and Measurement at http://aspe.hhs.gov/poverty/index.shtml

Household income categories:

Equal to or below the Federal poverty level indicate that the client's annual household income is the same as or below the Federal poverty level.

Within 101–200% of the Federal poverty level indicates that the client's income is equal to or no more than double the Federal poverty level.

Within 201–300% of the Federal poverty level indicates that the client's income is double or no more than triple the Federal poverty level.

More than 300% of the Federal poverty level indicates that the client's income is triple or more above the Federal poverty level.

Unknown/unreported indicates that the client's income is unknown or was not reported.

Housing/Living Arrangement

This field is to determine the client's homeless status Notes:

- This field is to be based upon residency eligibility to indicate what type of housing a client resides in as defined below
- This is a required field

2009 Instructions for the Ryan White HIV/AIDS Program Data Report Page 15

29. Housing arrangement categories

Report the number of clients according to their regular place of residence at the end of the reporting period, or most recent data available within the reporting period, using the categories defined below. Include infants, under the age of 2 whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

Housing/living arrangements:

Permanently housed includes clients who reside in apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.

Non-permanently housed includes clients who are homeless, as well as those living in transient or transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for living. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.

Institution includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health

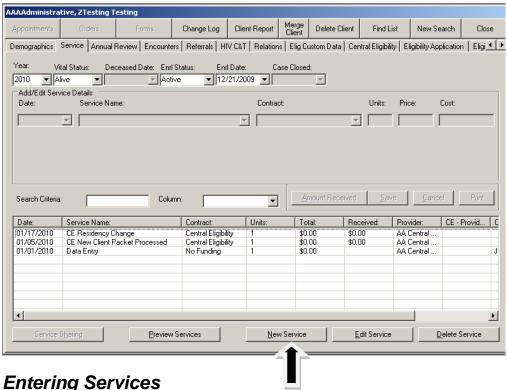
care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses.

Other includes other housing/living arrangements not listed above.

Unknown/unreported indicates that housing/living arrangements were not reported.

Service Entry

Services are entered for every service provided by an employee or subcontractor that represents your agency. The Part A administrative office will assist with the setup of services and contracts at the beginning of each contract year. In addition to services funded by Part A, each agency is required to report any valid Part A services regardless of funding source on the annual RDR report. So you will have a variety of services and contracts setup for data entry. These non-Ryan White funded services may be tracked in other systems outside of the Centralized CAREWare database.



Direct Client Service

- 1. Open the client record
- 2. Go to the service tab
 - Select New Service
 - i. Enter the Date, service provided, contract (funding source), # of units, service billable total and amount received (co-pay) (if applicable).
 - 1. Cost reimbursement contracts will reflect zero dollars for the unit of service provided.
 - ii. Custom service fields are also available to have data entered, if your agency has that setup, complete them as well.

b. Save

Cost Reimbursement and/or Anonymous Client Service

Entering Cost Reimbursement Services and/or anonymous based services:

- 1. Open the administrative entry client records
- 2. Go the service tab
 - a. Select New Service
 - i. Cost Reimbursement
 - 1. Enter the last day of the reporting period, select the appropriate service category budget line Item, # of units = 1, enter the billable amount.
 - ii. Anonymous activities
 - 1. Enter the day the activity occurred or the last day of the reporting period if you are entering the total for the billing period, select the appropriate service from the list, # of units enter the number of units provided, enter the billable amount if applicable.
 - iii. Save

Service Entry Considerations

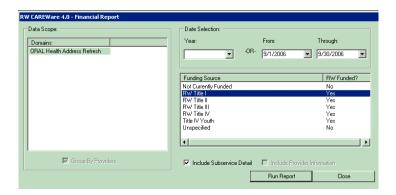
- A service must be entered on the day the service was provided
- Service entries may be entered at the end of the month, but for each encounter (date the client received a service) a service entry must be entered.

Group Rapid Service Entry

- 1. Create a custom report based on the criteria needed. This report will build a list for selecting who will have a service added. This is done from the custom reports module. If the provider wants all clients, build a report with just the field selections and sorting desired. Test the report that it gives the proper data. OR contact the Ryan White Part A program for assistance in developing the report.
- 2. From the main menu choose Rapid Service Entry.
- 3. Choose the option for group data entry.
- 4. Choose the custom report that was setup in step 1.
- 5. Check the box next to each client that the service will post to.
- 6. Click the link to create the service entry.
- 7. Select the date, type of service, and any other fields used for service entry.
 - a. NOTE: there is a problem with tabbing through the fields, it may reset a value already entered, just go back to that field and you will be fine. This has been reported to the programmers to fix the bug.
- 8. Click the link to review the entries, and then post

Financial Report

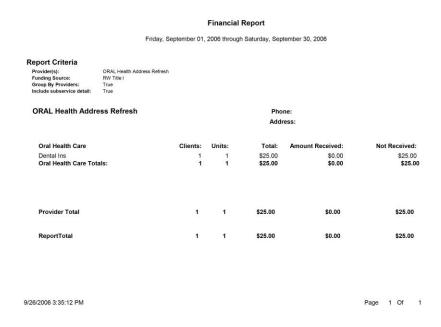
The Financial Report is a key element for the billing packet and must be included on every billing submission. This section discusses how to run the report as needed for the billing packet requirements. This report may be used for other internal agency needs as determined by each agency.



From the reports menu select financial report. Highlight the Part A funding source and enter the from and through dates (typically one month). Check the box to include sub service detail.

NOTES:

This is the key report that must submitted as your billing report. Effective January 2007 service entries must balance for billing to be approved.



Financial Report Notes

Service data entry is directly related to the amount your agency is going to bill to Part A. These entries must be complete and accurate.

You are required to report all client level data in the Central CAREWare database implemented and maintained by the Ryan White Part A program managed under Maricopa County General Government.

- 1. I am not sure how to go about balancing to CAREware
 - Contact Victoria Jaquez to get technical assistance
 - Get feedback from your internal financial person to assist
- 2. What do we do if unknown/unreported categories show on the crosstab reports?
 - Use the custom reports to create a report to find those clients and correct them.
 - Contact Julie Young if you need help creating a custom report
 - Determine if those are valid and then make sure you discuss this in the narrative portion of the billing packet.
- 3. What will cause our billing packet to be rejected and not processed for payment?
 - If the financial report that is run within the Part A office does not match to the report you submitted
 - If you do not include all the appropriate documents in the billing packet
 - Unknown/unreported data will not be acceptable for fields that determine eligibility, if you did not collect this data those activities are not eligible for reimbursement.
- 4. What will cause our billing to be adjusted
 - Activities reported to clients that are not eligible during the month of service will be considered disallowed. These activities will be used to reduce the billing as needed monthly.
 - Activities reported for clients that do not meet the FPL limits as defined on the current Menu of Services.
 - Case Management contracts have additional provisions that may require a reduction in a billing submitted, see Section 2 Service Specific Policies and Procedures regarding these provisions.

Referrals

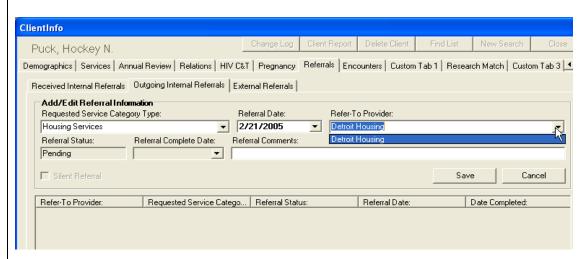
There are two types of referrals in CAREWare 4.X: **Internal** referrals are made between providers who are connected to a central database on a real-time network (for instance, a primary care provider and a housing agency both receiving funds from a Part A grantee). **External** referrals are made to providers who are not part of the real-time database network managed by the grantee. External referrals are the only type available to standalone users.

(i) Important difference between <u>Service</u> and <u>Referral</u>

A <u>service</u> is any service for which a provider pays **any** part. If you refer a client to a dermatologist, for instance, and you pay the copay for that visit out of your contract funds, that is a <u>service</u>; enter it in the Service tab. If you refer the client and pay no part of the cost of the visit, it is a <u>referral</u>; enter it in the Referral tab.

Making Internal Referrals on a realtime network of providers

To make a referral to another provider on your network, go to the Referrals tab and then click the 'Outgoing Internal Referrals' subtab:



- Select a service category, then enter the referral date. Only those providers within the network who provide services in the category you selected will be displayed on the Refer-To Provider pulldown menu.
- Referral Status and Referral Complete Date will be shaded out; the status defaults to "Pending."
 This setting will be changed by the receiving agency if and when the client follows through on the

referral.

When the internal referral service has been received and entered by the referred-to provider, this specific referral will automatically get set to 'Completed' and will be removed from the pending list.



□ About "Silent" Referrals

A "silent" referral allows you to make a referral with a higher degree of confidentiality. With a normal, internal referral, the receiving provider gets a system message when they logon informing them that a client has been referred (see screenshot on top of page Error! Bookmark not defined.). With a silent referral, the referred-to provider does not know the client has been referred until that client makes contact with that provider. The Ryan White Part A office does NOT encourage use of silent referrals in CAREWare.

For silent referrals, the referred-to agency will have to enter the client as a new client, at which time they will get the "possible duplicate client" menu, after which they will be notified onscreen that this client has been referred from another provider on the network.

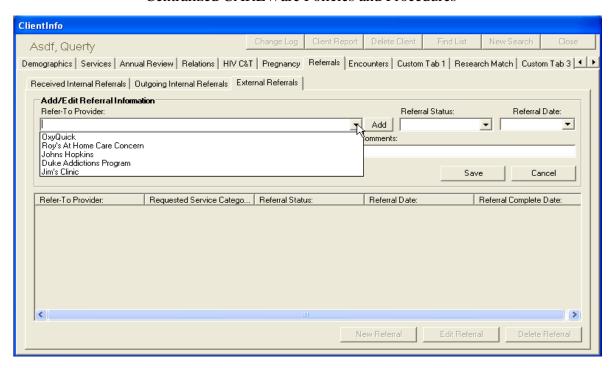
Silent referrals are more confidential than ordinary internal referrals. If the client never follows up on the referral, the other agency will never know that this individual is HIV-positive or in need of their services.

To make a silent referral, check the box under the Referral Status field. You may also edit outgoing referrals that have not been completed, and alter their silent/non-silent status.

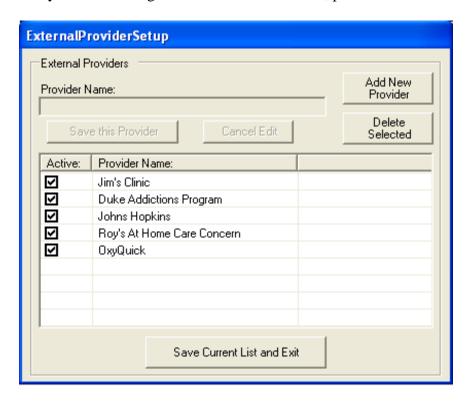
External Referrals

External referrals are for referrals made to non-Ryan White Part A providers. The updates must be tracked by the agency making the referral.

To make an external referral, go to the Referrals tab/External Referrals subtab. Whereas an internal referral begins with the service type and then "narrows down" the number of internal providers to whom you can refer a client for that type of service, the External Referrals is completely flexible. The Refer-To Provider pull down will show you all external providers to whom your agency has previously made referrals:



If the agency to whom you are referring the client is not on the list, push the **Add** button:



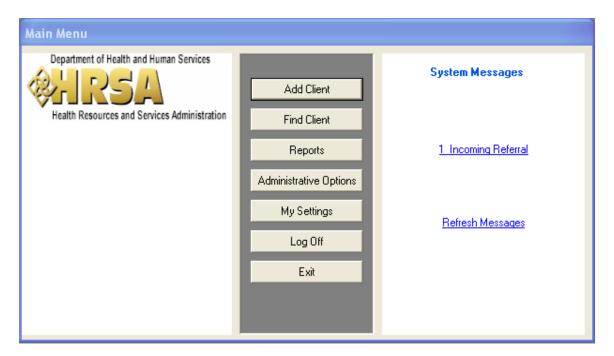
Select Add New Provider and enter the provider name, then select Save this Provider.

You cannot remove providers from the list to whom referrals have already been made, but you can remove them from the pulldown menu by unchecking the "Active" box next to their name.

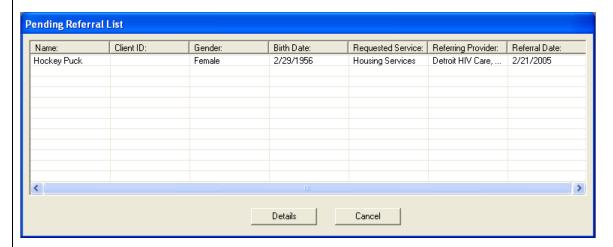
• New referrals should be marked "Pending." When the referral's status changes, you can return to this subtab, edit the status, and add the date the referral was rejected, completed or lost to follow-up.

Handling an incoming (non-silent) referral

Providers within a network will know when a client has been referred by another provider when they see a system message on the right-hand side of the main menu screen.



Click on the link to the incoming referral, select a referral and press **Details**, or double click the line item:



NOTE: Clicking "refresh messages" will refresh the system messages on the main menu. If you have one referral, and act on it, and refresh messages, that incoming referral message will disappear.

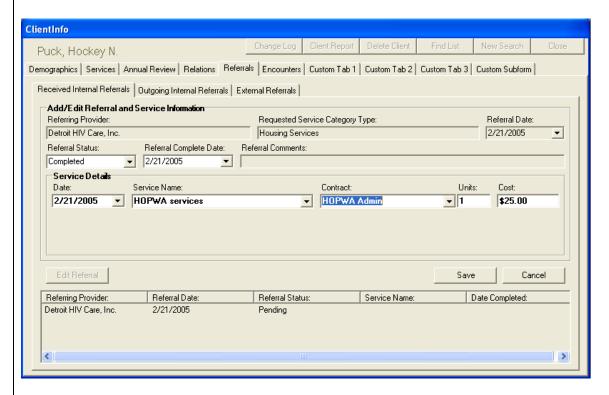
If the client is already a client of both providers, when you open the referral you will be taken directly to the Referrals tab/Received Internal Referrals subtab.



Handling an incoming (non-silent) referral (cont'd)

If the client is not yet a client of the agency receiving the referral, that agency will see the "Possible Duplicate Client" message (see page Error! Bookmark not defined.). This will prompt them to link their agency to this client's record.

Select any referral at the bottom of the screen, double-click it or press **Edit Referral**:



You can enter a service record directly on this screen (it will show up under the Services tab when you're done).

Entering a service automatically changes the Referral Status to "Completed" and the Referral Complete Date to the date of the service. Or, you can mark the referral status "Completed" with a completion date without entering any service.

Central Eligibility Tab

Centralized Eligibility

CAREWare will be used to manage the eligibility status of a client across all providers. This system does not have the capabilities to pop up messages regarding client status and requires each end user to understand which screens must be reviewed to determine the current client status.

Each defined service has different eligibility requirements in regards to FPL guidelines and various sources for other payers (ensuring that RW Part A is the payer of last resort). This system does not have the capabilities to pop up messages regarding these additional eligibility requirements and requires each end user to understand which screens will assist them in assessing any additional requirements. Each agency must have a system for verifying other payers when medical insurance coverage is potentially available to the client. Centralized eligibility is only a tool for assisting with the assessment of FPL and other payers.

Documentation requirements that are not tracked within the CAREWare system are: Release of Information to Maricopa County and Inter-provider, Client Grievance procedures and client rights and responsibilities. These are all documents that must be collected and maintained in a client chart for review and auditing purposes.

Client Eligibility Status Verification

- 1. Client Status
 - a. Providers must review the Central Eligibility tab to determine if a client is eligible for services. This tab will give a snapshot status on overall client status, due dates for documentation required, FPL calculation and other payer sources.
 - b. Client Eligibility Status
 - i. Eligible This indicates that the client can receive services.
 - ii. Not Eligible Indicates the client must provide documentation to receive services
 - 1. A reason is stated to indicate what needs to be done to bring up the clients eligibility.
 - iii. Pending This indicates the client is in a 30 day period to provide documentation to continue services, the client is still eligible for services
 - c. FPL determines the income level for a client
 - i. 1 = 0-100%
 - ii. 2 = 101-200%
 - iii. 3 = 201-300%
 - iv. 4 = 301-400%
 - v. 9 = 401- and above or No Annual Income is indicated so can not be calculated

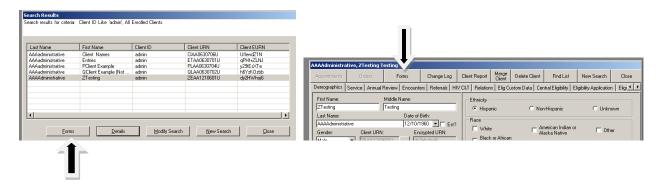
Provider Data Collection

1. Providers will collect from clients the approved eligibility documents: proof of HIV status, Income Verification, Residency Verification and proof that Ryan White Part A is the payer of last resort and a Eligibility application with appropriate signatures.

- 2. Providers must utilize the approved methodology as defined in the policy to calculate the annual income of a client based on income documents received and number in household. This is a vital calculation because it determines the clients FPL used in each defined service.
- 3. Providers will enter all data in the CAREWare system utilizing the predefined forms established to flow with the applications received.

CAREWare Data Entry Forms

Data entry is accomplished by entered the information using the forms developed within CAREWare. To locate the forms start by locating a client using the find client button. From here you can go directly into forms or into the detail demographic screen.



Once in forms the screen below displays:



Form Notes

- You will not see forms created by other agencies when looking at a client record
- To print a form, save the form and choose to view the form You will have an option to print

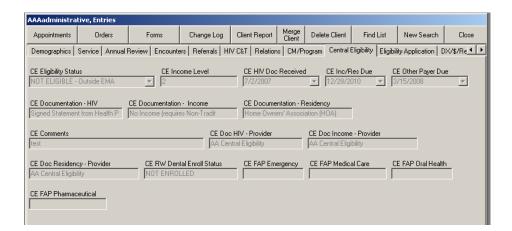
Ryan White Part A Status Updates

- 1. CAREWare will be updated based on the above various data collection procedures.
- 2. The update will occur at the end of the business day.

- 3. The updater is run when a service entry is made that indicates a provider has accepted a client packet.
- 4. The updater validates the following:
 - a. All data entry requirements are met for RDR/RSR data entry as well as CE data entry
 - b. Client's County is either Maricopa or Pinal
 - c. Client's FPL is at or below 400%, otherwise they are not eligible
- 5. The updater does not validate the following:
 - a. Data entry matches the application completed by the client
 - b. Spelling

SPECIAL NOTES:

- 1. You must follow the Central eligibility documents to ensure that all required data is collected
- 2. Never change valid information to unknown/unreported. This data is shared between agencies so although you may not have received the answer to the question does not mean that another provider did not. As you get the questions answered by a client you may remove/change the status from unknown/unreported to the information you received.



CE Eligibility Status

This is a calculated field based upon the verification documents entered under the services tab by the Ryan White Part A office.

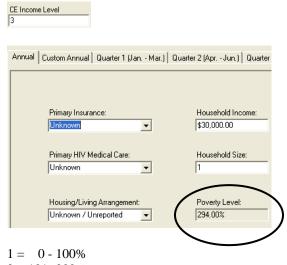


- Current All Eligibility Documents have been received
- Not Eligible Indicates the client is not eligible for service and which documents are missing

- Pending Indicates the client is currently within a 30 day grace period, so they are eligible for services but are due to provide documents.
- No Central Documents
 - o This status indicates that the AA office has not received/verified the appropriate documents to show a client has been initially enrolled into the system.
 - New Clients
 - They will be given a pending status for 30 days to allow for providers to receive the documents from the client. The client is eligible for services but is currently due to provide documents.

CE Income Level

This is a calculated field based upon the current calculation for from the Annual tab. This field is used to determine if the client meets the FPL eligibility limits for a service. Clients with a 9 are not eligible for any Ryan White Part A Services.



- 2 = 101- 200%
- 3 = 201 300%
- 4 = 301 400%
- 9 = 401 and above or No Annual Income/Household Size is indicated is so can not be calculated

CE HIV Doc Received

This is a calculated field.



CE Inc/Res Due

This is a calculated field. The field indicates when recertification of client's eligibility is required.

(Other Payer due field will be retired during 2010/2011 grant year and is not used in the new CE process effective March 1, 2010)

CE Documentation

These are calculated fields. The type of document and/or how the documents met the eligibility policy is displayed



CE Provider Received

These are calculated fields. These fields indicate which provider processed the last packet for the client.



CE Comments

This is an information only field and will be used to indicate the status of a CE packet.



CE RW Dental Enroll Status

This field is calculated based on the current Office of Oral Health – Delta Dental status.



CE FAP Fields

These fields are calculations for Case Management providers to know the totals a client has received in FAP for the current grant year.

Form Data Entry Requirements

When a CE packet or change to a client has been processed by a provider, each provider must post a service entry indicating what occurred. This is the way the CE updater will know to go ahead and recalculate the CE status for the client. Each provider will only see the old CE verification services (through February 28. 2010) and the services they post to the system. To verify which provider has processed a packet for a client, you will need to open a client information form or look at the Central Eligibility Tab.

Form/Service Entry Best Practices

To ensure the forms can update the client record properly, please post the appropriate service entry first before creating and entering data in the client forms. Note: A CE service entry is required for processing a change to a client eligibility data as well as processing a client packet.

AHCCCS Applications

Data entry requirements exist for agencies with the following:

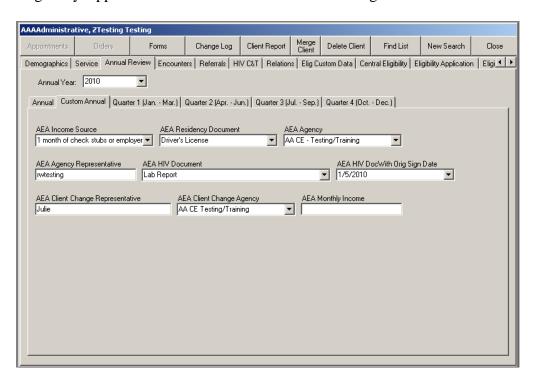
- Agencies that have submitted/assisted with submission of an AHCCCS eligibility packet must indicate the date of the AHCCCS application in CAREWare
- Agencies that have received an approved/denied AHCCCS letter through a client must indicate the date and status in CAREWare for any client that they collect eligibility documentation for
- Note: These fields can be completed when a client packet is processed and/or by using the client info form

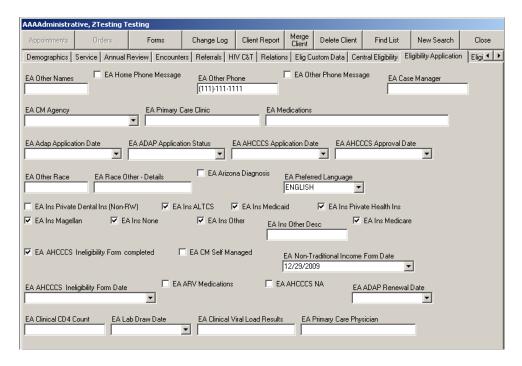
Eligibility Status How to Tell

- Within the client record, go to the CE tab and view the status
- To print out the status
 - Go to the client Record and Choose client Report Two page, the status will print on the top of page two
 - o Go to the client Record Forms and create/print a Client Info Form

Custom Eligibility Application Fields

The new Eligibility process uses a few forms to allow for ease of data entry. Because of the use of forms there are custom fields located within the Annual Review tab and the Third Custom Tab – labeled Eligibility Application. Below are screen shots showing the information stored on those two tabs.





Ryan White Program Data Report (RDR)

Who Completes the Ryan White HIV/AIDS Program Annual Data Report?

The Ryan White HIV/AIDS Program Annual Data Report should be completed by all Ryan White HIV/AIDS Program Part A (formerly Title I), Part B (formerly Title II), Part C (formerly Title III), and Part D (formerly Title IV), including the Adolescent Initiative, funded grantees, service providers, and Part B consortia. *Grantee of record* is the official Ryan White HIV/AIDS Program grantee that receives Federal funding directly from the Health Resources and Services Administration (HRSA). This agency may be the same as the provider agency or may be the agency through which the provider agency is subcontracted.

The *service provider* is the agency that provides direct services to clients and their families and is funded by the Ryan White HIV/AIDS Program. Services may be directly funded by one or more Parts of the Ryan White HIV/AIDS Program or through subcontract(s) with official Ryan White HIV/AIDS Program grantees of record. If the only services you provided during this reporting period were (1) planning or evaluation, (2) administrative or technical support, (3) fiscal intermediary services, (4) technical assistance, (5) capacity development, or (6) quality management, please complete Section 1, Items 1–16 only.

Providers who receive funds under more than one Part should complete this form ONLY once. Include information from all Parts under which you are funded.

Which Clients Should be Included in the RDR Report?

Providers should report data on all clients who received services **eligible** for the Ryan White HIV/AIDS Program Parts A, B, C, and/or D including Adolescent Initiative funding, regardless of the actual funding source used to pay for those services. Grantees and providers that choose to report only on the subset of clients who received funded services from any Part of the Ryan White HIV/AIDS Program must have special permission from their HRSA Project Officer (See Section 1.2: Reporting scope for more information).

Reporting period

Enter the start and end dates of the reporting period for the provider agency. *Reporting period* is a calendar year, January 1 through December 31. The data are reported to HRSA by March 17, 2008. All information reported on clients and service delivery should reflect the calendar year

reporting period. The reporting period may be shorter than a year if a provider agency did not receive Ryan White HIV/AIDS Program funding for an entire calendar year. In this case, the beginning or end dates of the reporting period should reflect the exact time period in the calendar year during which services were delivered to clients. For example, the reporting period for a provider whose contract began on April 1 would be April 1–December 31. Similarly, the reporting period for a provider whose contract was effective on January 1 but discontinued on June 30 would be January 1–June 30, 2007 Instructions for the Ryan White HIV/AIDS Program Data Report 5

HRSA Link

http://hab.hrsa.gov/tools.htm#data

Provider Requirements

- Data verification Missing Data Reports Missing CADR Report in CAREWare Set the range of dates from 1/1/YYYY-12/31/YYYY
 - o From the CAREWare Reports Menu
 - Missing CADR Report (All fields)
 - Missing RDR Annual Review Fields Only ***
- Clean up missing/incomplete data ***

(These should be reviewed with monthly reporting)

Key fields to examine are those on the Annual Tab

Insurance

Medical

Housing

- Run RDR report in CAREWare
- Reports RDR
 - o Review the results with the RDR report requirements (CAREWare calculates all fields for you if the data was entered)
 - i.e., Medical Section Clinical Data may need produced from your other systems
- Review Process

Provide any additional data that is deemed missing from upload

Review revised RDR report

Approve final report – send email to <u>julieyoung@mail.maricopa.gov</u>

Part A Requirements

- o Create export file from CAREWare
- Upload data report to CAREWare
- o Review and clean up errors on HRSA web submission site
- Provide report to providers for review
- Accept document after provider approval
- Provide final report to providers for their records

Reporting Timeline

- January CAREWare system update with RDR Report
- January Provider Conference Call
- January 31st RDR Reports Due to Part A office
- February 1st through February 25th RDR Reports Data Entry to HRSA
- February 1st through March 10th RDR Reports Provider Approval
- March 15th RDR Reports Grantee Approval

Ryan White Program Services Report (RSR)

The Ryan White HIV/AIDS Program Services Report, or the RSR for short, is comprised of:

- The Grantee Report. Grantees will complete this report online through the HRSA Electronic Handbooks
 (EHBs) using a web-based data entry system. Besides providing basic information about their
 organization, they will view, update, and verify a pre-filled list of their service provider contracts that were
 active in the most recent reporting period. For each of the contracts, grantees will view a list of Ryan
 White Program services and then check the boxes next to all services that their organization funded
 under the contract.
- The Service Provider Report. Service providers will complete this report online. In addition to providing some basic information about their organization, providers will view a pre-filled list of their active service provider contracts for the most recent reporting period. For each of the service contracts, providers will view a list of Ryan White Program services and check the boxes next to all services that their organization delivered to RW Program clients during the reporting period.
- The Client Report. Each service provider will submit this report online as an electronic file upload using a standard format. Each upload file will contain one record per client. Each client record will include information on demographic status, HIV clinical information, HIV-care medical and support services received, and the client's 'UCI', an encrypted, unique client identifier.

Who Completes the Service Provider Report?

All agencies that provide direct client services must complete <u>one</u> Service Provider Report online. Multiply-funded providers will include information from all program Parts under which the agency is funded.

A service provider that also is a grantee—a "grantee-provider"—must complete the Web-based Provider Report. In addition, a grantee-provider of outpatient/ambulatory medical care services and/or case management services (medical or non-medical) must submit a Client Report.

- A service organization that has a contract with a RWHAP grantee is considered a first-line provider A
 first-line provider must complete the Web-based Provider Report, and a first-line provider of
 outpatient/ambulatory medical care services and/or case management services (medical or non-medical)
 must submit a Client Report.
- A service organization that enters into a contract with a first-line provider is considered a second-line provider. A second-line provider must complete the Web-based Provider Report, and a second-line provider of outpatient/ambulatory medical care services and/or case management services (medical or non-medical) must submit a Client Report.

Who Completes the Client Report?

All agencies that provide direct client services must complete <u>one</u> Service Provider Report online. Multiply-funded providers will include information from all program Parts under which the agency is funded.

A Client Report must be submitted for all service providers that were funded by the RWHAP to provide core medical or support services directly to clients. Grantees may decide on a case-by-case basis whether to require the service provider to submit its own client data or if the grantee will submit the provider's client data on behalf of the provider.

The client report should contain one record ("row" of data in a database) for each client who received an RWHAP-funded core medical service or support service during the reporting period. The data elements reported per client are determined by the specific RWHAP-funded service(s) the client received at your agency. HAB does not require or want grantees or providers to report a client's service data for any services he/she received that were NOT paid for by the Ryan White HIV/AIDS Program. See the chart "Required Client-Level Data Elements

for RWHAP Eligible Services" in Appendix A to determine the minimum client-level data elements that will be reported for a client based on the RWHAP-funded service(s) he or she received.

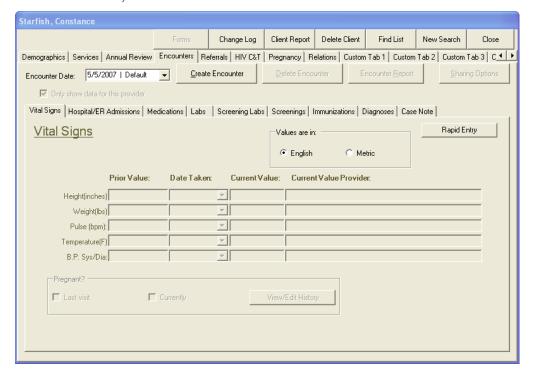
All client level data reported within CAREWare is used to create the client level report within the CAREWare interface. The services provided and demographic field requirements as well as clinical data entry requirements are listed in this manual. As new information becomes available supplemental documents will be provided as guidance to these HRSA level reporting requirements.

Clinical Data Entry for Bi-Annual Data Report

Clinical data entry is only to be completed by providers offering primary medical care.

Entering Clinical Encounter Data

Open the client's record, then click on the Encounters tab.



There are two ways to enter clinical data.

You can choose **Create Encounter**, which allows you to enter all the data associated with an encounter date (i.e. a doctor visit), or

You can choose **Rapid Entry**, which allows you to enter just one subset of data (e.g. labs or screenings) on any date, on or off a formal clinical encounter. For details on Rapid Entry, please see the complete User Manual. It is only in Rapid Entry that you can print graphs of lab tests and vital signs over time.

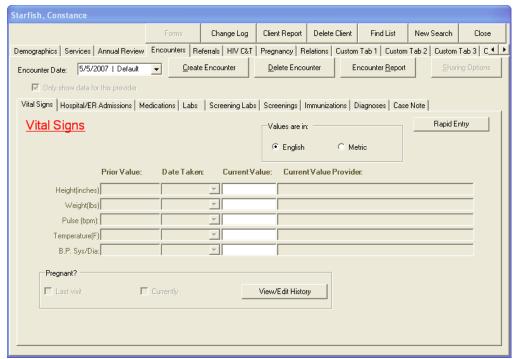
Create Encounter

Click Create Encounter to create an encounter.



You will be prompted to enter the encounter date; the system defaults to today's date. You can type in a different date or use the arrow to bring up the drop-down calendar. Click **Create Encounter** after entering the date. To back enter data for a clinical encounter, select the appropriate encounter date.

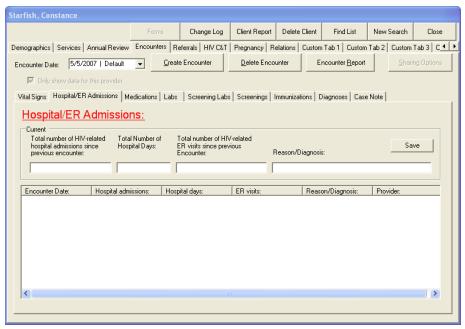
Vital Signs



Choose English or Metric values. You only need to enter Height once; this will roll over to future encounters (of course, you'll need to change this for children).

Vital signs data is not required for the RSR reporting.

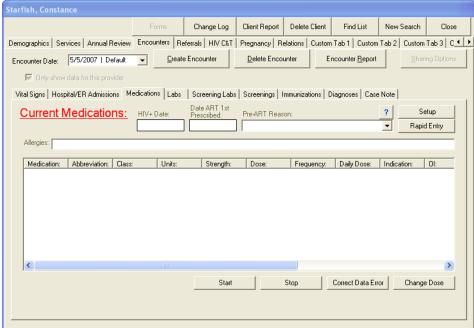
Hospital/ER Admissions



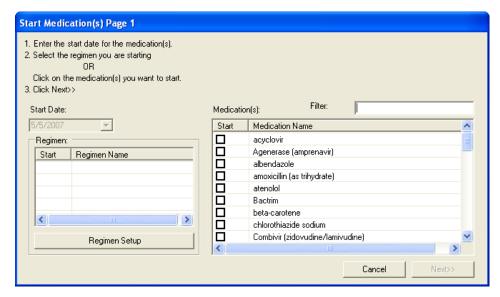
These fields are self-explanatory; click **Save** when done.

Medications

Entry of medications is required for the RDR/RSR reporting requirements. The only way to report if a client is on HAART is through entry of each medication in the medication tab.

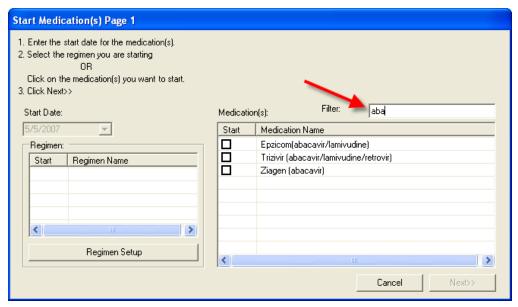


1. Click **Start** to enter a new medication.



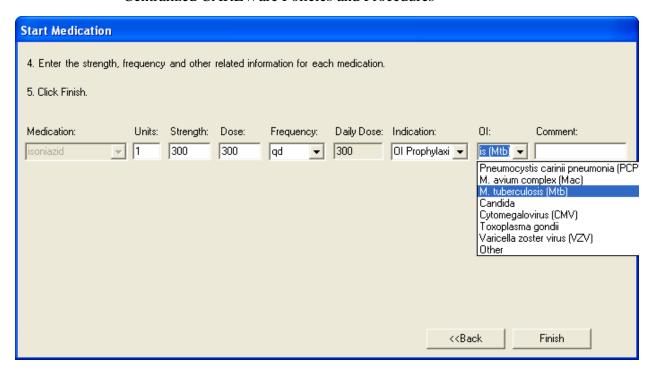
The start date is grayed out as the encounter date = start date. Scroll through the list of medications and select the check box next to the med or meds to start. You can also create a Regimen or group of antiretrovirals that will ease data entry by starting all the medications in the regimen at once.

You can use the Filter to do a quick find. Type several of the letters in the medication's name to automatically reduce the length of the list. For example, typing "aba" will bring up all drugs with abacavir.

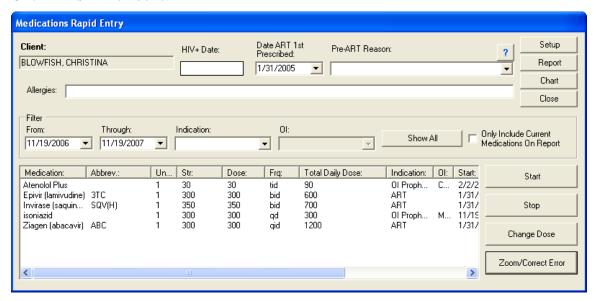


2. Click **Next** to enter strength, frequency, etc. Indicate whether the medication is ART, Opportunistic Infection (OI) treatment, OI prophylaxis or other. If this is an OI med, the OI drop down box will activate so you can choose the OI being treated.

IMPORTANT: For the Annual Data Report, medical section 5, CAREWare looks to these fields—Indication and OI- to determine how many antiretroviral medications the client is on (if any) and if a client has been or is currently being treated for TB Prophylaxis or Disease.

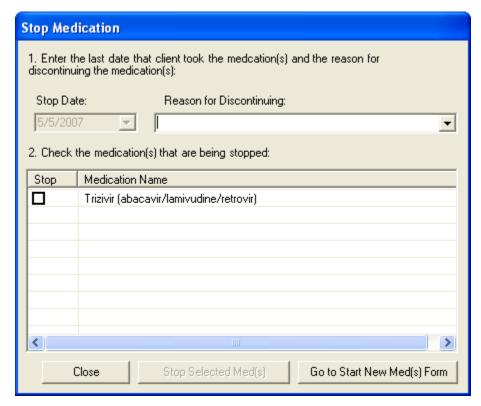


3. Click **Finish** when done.

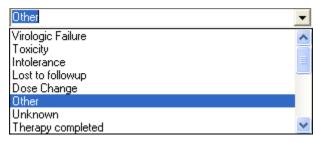


If you indicated that the drug was ART, the **Date ART 1**st **Prescribed** field will autopopulate with the start date of the first ART drug entered. The **HIV+ Date** comes from information entered in the Demographics tab. If the client is not yet on ART, you can enter a **Pre-ART Reason** from the drop down menu.

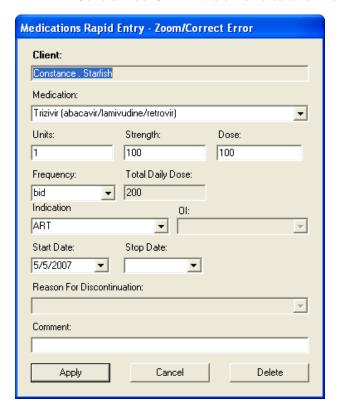
4. To stop a medication, click on **Stop**.



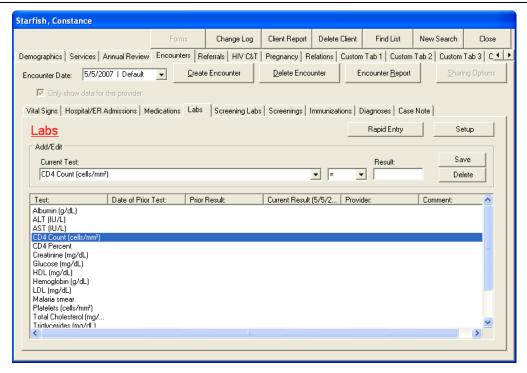
Reason for Discontinuing menu:



- 5. Select the reason for discontinuing from the drop down menu, check the medication to be stopped. Click **Close** if you are done with meds, or click **Go to Start New Med(s) Form** to start the client on a new med.
- 6. To make changes, click on a med to highlight it and click **Correct Data Error**. The edit screen will appear. Make any necessary changes and click **Apply**.

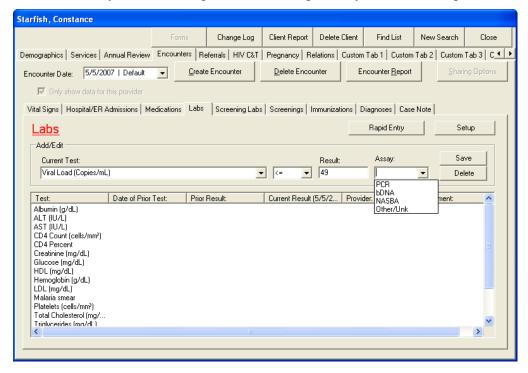


LabsDesignated for tests with a quantitative (numeric) result



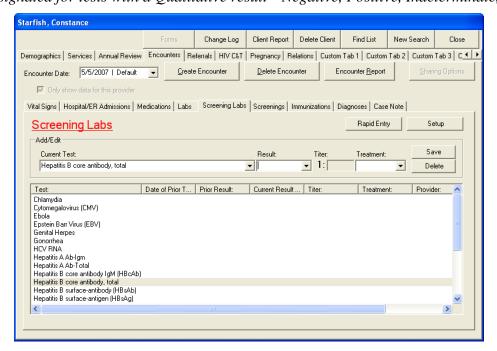
7. Click on any test or select one from the **Current Test** drop down menu.

- 8. Select whether the result is =, <= or >=.
- 9. Enter the value in the Result box.
- 10. For viral load, you have the option of selecting "Assay" from the drop down menu.



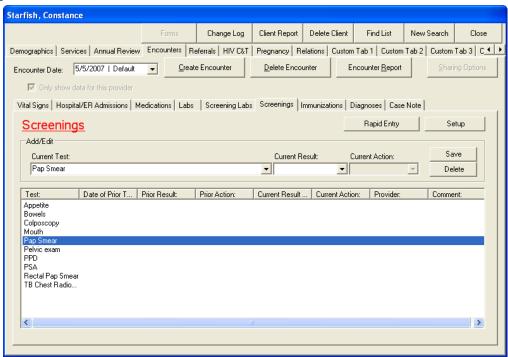
Screening Labs

• Designated for tests with a Qualitative result—Negative, Positive, Indeterminate, etc.



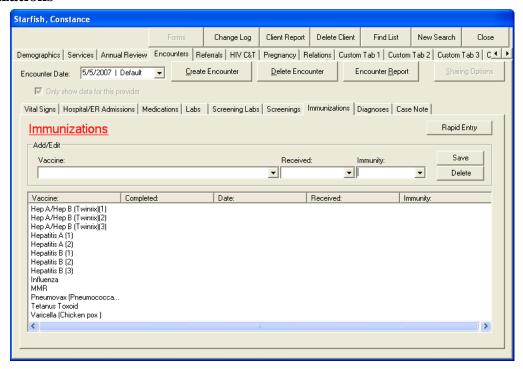
- 11. Click on any test or select one from the **Current Test** drop down menu.
- 12. Select the **Result** from the drop down menu. (NMI or Not Medically Indicated is often selected for hepatitis tests to indicate that the client has already been exposed; this prevents your reports from counting these clients as not having been tested for hepatitis.)
- 13. The **Titer** field will activate for tests where titer is indicated (syphilis, etc.).
- 14. Select a **Treatment** from the drop down menu.
- 15. Click Save.

Screenings



- 1. Click on any test or select one from the **Current Test** drop down menu.
- 2. Select the **Current Result** from the drop down menu. Data in the drop down is test dependent, i.e. if you select PPD you'll see Negative <5mm, Positive >5mm, Client did not return for reading, etc.
- 3. Select a **Current Action** if applicable.
- 4. Click **Save**.

Immunizations



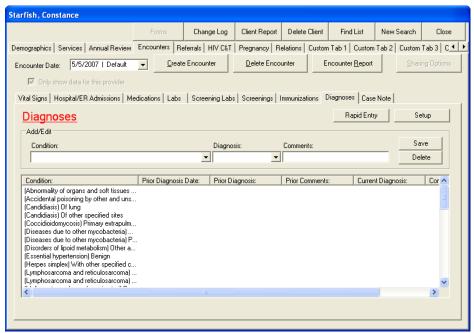
- 1. Click on any test or select one from the **Vaccine** drop down menu.
- 2. Select the appropriate value from **Received**.
- 3. Select the appropriate value from **Immunity**.

There are often cases where a client has either been vaccinated prior to entering your care (hepatitis, pneumovax) or has already been exposed and requires no vaccination. In these cases you would select "NMI" under **Received** and "History of immunization" or "History of vaccination" under **Immunity**.

4. Click **Save**.

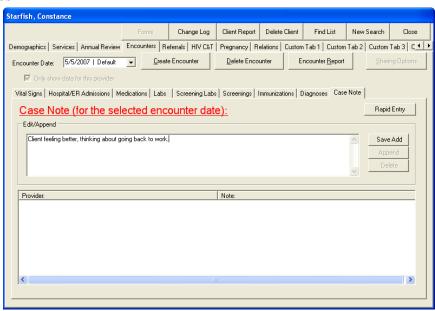
NOTE: Immunization data for Hepatitis B vaccinations are required for RDR/RSR reporting requirements. Hep B 3rd dose or Twinrix 3rd dose are required entries to report that Hep B vaccinations are completed for a client.

Diagnoses



- 1. Click on any condition or select one from the drop down menu.
- 2. Select diagnosis from the drop down menu.
- 3. Enter any comments.
- 4. Click **Save**.

Case Notes



1. Type a case note in the **Edit/Append** box and click **Save Add** when done.

Special Instructions

- a. Data entry requirements are a minimum of a quarterly chart review and clinical data collected during that specific quarter
- b. Fields that are free text and or case notes do not require any data entry. Entry in these fields would be for use by the provider and are not used for data collected on RDR or RSR reporting
- c. RDR/RSR reporting do not require data entry related to vital signs and/or Immunizations, except for Hepatitis B vaccines. Requires Either Hep B third dose or Twinrix 3rd dose.
- d. HIVQual data and/or QM standards of care data should be collected on the clinical encounter tabs to allow for grantee reporting requirements to be met.
- e. Data reported in CAREWare is subject to chart reviews to ensure accuracy of data.
- f. Medications used in treating HIV and TB are necessary for all data calculations to be accurate for RDR/RSR reporting.
- g. Female patients must have papsmear screenings and pregnancy data entered for the RDR/RSR reporting requirements. Papsmear screenings also require a pelvic exam entered to be considered a complete test.
- h. Diagnosis should include all diagnosis that are indicated in the client chart based upon the clinical OP visit data. This includes non HIV related diagnosis.
- i. Screening/Lab data is required for CD4, Viral Load, TB screening, STD screening, and Hepatitis C screening.
- j. Treatment data for TB and Hepatitis diagnosis are required.

Miscellaneous

Seeking Assistance

There are two sources of assistance for CAREWare related issues.

For VPN card related issues, contact the Maricopa county IT help desk at 602-506-HELP or 602-506-4951.

For CAREWare lockout or other CAREWare related issues, contact the administrative assistant of the Ryan White Part A Program.

Permission Descriptions

Below are the descriptions of the permission templates in the CAREWare User Agreement. For custom templates for your agency, please contact the Administrative Agent.

Data Entry: Variety of permissions that allows user to enter billing items, RDR/RSR items and eligibility documentation

Add Client: Allows user to search CAREWare database and add client.

Delete Client: Allows user to delete client and delete service entries.

Referrals: Allows user to receive, send and process referrals. Also provides access to reporting on referrals.

Reporting: Allows user to access RDR/RSR reporting, financial reporting and custom reporting

Clinical Data Entry: Only appropriate for primary medical care providers. Allows access to primary medical care related RDR/RSR reporting elements.

View Only: Allows user to review billing and user data without making any changes to data entry.

GLOSSARY OF RYAN WHITE HIV/AIDS PROGRAM DATA REPORT TERMS

Active client

continuing in

program

An individual who was a client when the period started and continued in the program.

Active client new to

the program

A client whose first point of contact with the program occurred during this reporting period. **ADAP** *AIDS Drug Assistance Program*—A State-administered program authorized under Part B of the

Ryan White HIV/AIDS Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

ADAP Flexibility

Policy

HIV/AIDS Bureau's (HAB) Policy Notice 00-02 provides grantees greater flexibility in the use of ADAP funds and permits expenditures of ADAP funds for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications.

NOTE: Grantees *must* request in writing to use ADAP dollars for services other than medications.

Administrative or

technical support

The provision of qualitative and responsive "support services" to an organization. Services may include human resources, financial management and administrative services (e.g., property management, warehousing, printing/publications, libraries, claims, medical supplies, and conference/training facilities).

Affected client A family member or partner of an infected client who receives at least one Ryan White

HIV/AIDS Program support service during the reporting period.

Agency reporting for

multiple fee-forservice

provider

An agency that reports data for more than one fee-for-service provider.

Aggregate data Combined data, composed of multiple elements, often from multiple sources. For example,

combining demographic data about clients from all primary care providers in a service area generates aggregate data about client characteristics.

AIDS *Acquired immune deficiency syndrome*—A disease caused by the human immunodeficiency virus.

American Indian or

Alaska Native

An individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Anonymous client No identifying information is collected from the client.

APA AIDS Pharmaceutical Assistance—A local pharmacy assistance program implemented by a Part

A EMA/TGA, a Part B State, or a Part C or D agency. The Part B grantee consortium or Part A planning council contracts with one or more organizations to provide HIV/AIDS medications to

clients. These organizations may or may not provide other services (e.g., primary care, case management) to the clients that they serve through a Ryan White (or other funding sources) contract with their grantee. (See **ADAP** and **Local/Consortium Drug Reimbursement**

Program)

ARV Antiretroviral—A substance that fights against a retrovirus, such as HIV. (See **retrovirus**) **Asian** An individual having origins in any of the original peoples of the Far East, Southeast Asia, or

the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

34 2007 Instructions for the Ryan White HIV/AIDS Program Data Report

Black or African

American (not

Hispanic)

An individual having origins in any of the black racial groups of Africa, but not of Hispanic ethnicity.

Capacity

development

A set of core competencies that contribute to an organization's ability to develop effective HIV health care services, including the quality, quantity, and cost effectiveness of such services. These competencies also sustain the infrastructure and resource base necessary to develop and support these services. Core competencies include: management of program finances; effective HIV service delivery, including quality assurance; personnel management and board development; resource development, including preparation of grant applications to obtain resources and purchase of supplies/equipment; service evaluation; and cultural competency development.

Case management

services (medical)

(See medical case management services)

Case management

services (nonmedical)

Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does..

CD4 cell count The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good

predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1,500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm₃. If the count is lower, testing every 3 months is advised. A CD4 count of 200 or less indicates AIDS.

CD4 or CD4+ cells Also known as "helper" T-cells, these cells are responsible for coordinating much of the

immune response. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.

CDC Centers for Disease Control and Prevention—The DHHS agency that administers HIV/AIDS

prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers AIDS surveillance grants, and publishes epidemiologic reports such as the HIV/AIDS

Surveillance Report.

CEO Chief Elected Official—The official recipient of Part A Ryan White HIV/AIDS Program funds

within the EMA/TGA, usually a city mayor, county executive, or chair of the county board of supervisors. The CEO is ultimately responsible for administering all aspects of the Ryan White HIV/AIDS Program in the EMA/TGA and ensuring that all legal requirements are met. In EMAs/TGAs with more than one political jurisdiction, the recipient of Part A Ryan White HIV/AIDS Program funds is the CEO of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of people with AIDS in the EMA/TGA.

Child care services The provision of care for the children of clients who are HIV-positive while the clients are

attending medical or other appointments or attending Ryan White HIV/AIDS Program-related meetings, groups, or training. This does not include child care while the client is at work.

Client (See infected client or affected client)

Co-morbidity A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

Combination therapy Two or more drugs or treatments used together to achieve optimum results against HIV

infection and/or AIDS. For more information on treatment guidelines, visit http://www.aidsinfo.nih.gov/guidelines.

2007 Instructions for the Ryan White HIV/AIDS Program Data Report 35

Confidential Information such as name, gender, age, etc., that is collected on the client, and the client is

reassured that no identifying information will be shared or passed on to anyone.

Consortium/HIV Care

Consortium

An association of one or more public, and one or more nonprofit private, health care, and support service providers, people with HIV/AIDS, and community-based organizations operating within areas determined by the State to be most affected by HIV disease. The consortium agrees to use Part B grant assistance to plan, develop, and deliver (directly or through agreement with others) comprehensive outpatient health and support services for individuals with HIV disease. Agencies comprising the consortium are required to have a record of service to populations and sub-populations with HIV.

Continuum of care An approach that helps communities plan for, and provide, a full range of emergency and longterm

service resources to address the various needs of PLWHA.

DCBP *Division of Community-Based Programs*—The division within HRSA's HIV/AIDS Bureau that

is responsible for administering Part C, Part D, and the HIV/AIDS Dental Reimbursement Program.

Dispensing of

pharmaceuticals

The provision of prescription drugs to prolong life or prevent deterioration of health.

DSP *Division of Science and Policy*—The division within HRSA's HIV/AIDS Bureau which serves

as the principal source of program data collection and evaluation, the development of innovative models of HIV care, and the focal point for coordination of program performance activities and development of policy guidance.

DSS *Division of Service Systems*—The division within HRSA's HIV/AIDS Bureau that is responsible

for administering Part A and Part B including the AIDS Drug Assistance Program (ADAP). **DTTA** *Division of Training and Technical Assistance*—The division within HRSA's HIV/AIDS Bureau that is responsible for administering the AIDS Education and Training Centers (AETC) Program and technical assistance and training activities of the HIV/AIDS Bureau.

Dual therapy The use of two antiretroviral drugs at one time to reduce the amount of detectable HIV.

Early intervention (See HIV/EIS—HIV/Early Intervention Services/Primary Care) EIS for Parts A and B Early intervention services for Parts A and B include counseling individuals with respect to

HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Eligibility criteria The standards set by a State ADAP, usually through an advisory committee, to determine who

receives access to ADAP services. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL), such as 200% FPL. Medical eligibility is most often a positive HIV diagnosis. Eligibility criteria vary among ADAPs.

EMA/TGA *Eligible Metropolitan Area/Transitional Grant Area*—The geographic area eligible to receive

Part A Ryan White HIV/AIDS Program funds. The boundaries of the eligible metropolitan area/transitional grant area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the CDC. Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend across more than one State.

Emergency financial

assistance

The provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. Part A and Part B programs must be allocated and tracked, and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).

36 2007 Instructions for the Ryan White HIV/AIDS Program Data Report

Epidemic A disease that occurs clearly in excess of normal expectation and spreads rapidly through a

demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

Exposure category (See risk factor)

Faith-based

organization

An organization that is owned and operated by a religiously affiliated entity, such as a Catholic hospital.

Family centered A model in which systems of care under Ryan White Part D are designed to address the needs of

PLWHA and affected family members as a unit, by providing or arranging for a full range of services. The family structures may range from the traditional, biological family unit to nontraditional

family units with partners, significant others, and unrelated caregivers.

Family members Includes children, partners, biological parents, adoptive parents, foster parents, grandparents,

other caregivers, and siblings (who may or may not be living with HIV).

Fiscal intermediary

services

Reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts.

Food bank/homedelivered

meals

The provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

FTE *Full-time equivalent*—A standard measurement of full-time staff (either paid or volunteer), which is based on a 35 to 40 hour work week. It is calculated by taking the sum of all hours worked by staff and dividing by 35 to 40, depending on how your organization defines full-time employment. For example, 2 staff members who work 20 hours each per week represent 1 FTE, assuming full-time employment is defined as 40 hours per week.

Grantee of record The official Ryan White HIV/AIDS Program grantee that receives Federal funding directly from

the Federal government (HRSA). A grantee may also be a provider if it provides direct services in addition to administering its grant.

HAART *Highly active antiretroviral therapy*—An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels.

HAB HIV/AIDS Bureau— The Bureau within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) that is responsible for administering the Ryan White HIV/AIDS Program. Within HAB, the Division of Service Systems administers Part A, Part B, and the AIDS Drug Assistance Program (ADAP); the Division of Community-Based Programs administers Part C, Part D, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers (AETC) Program. The Bureau's Division of Science and Policy administers the SPNS Program, HIV/AIDS evaluation studies, and the Ryan White HIV/AIDS Program Data Report.

Health education/risk

reduction

The provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling, to help clients with HIV improve their health status.

Health insurance

premium & cost

sharing assistance

The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Hemophilia/

coagulation disorder

Individuals with delayed clotting of the blood.

2007 Instructions for the Ryan White HIV/AIDS Program Data Report 37

Heterosexual contact Individuals who report specific heterosexual contact with an individual with, or at increased risk

for, HIV infection (e.g., an injection drug user).

High-risk insurance

pool

A State health insurance program that provides coverage for individuals who are denied

coverage due to a pre-existing condition or who have health conditions that would normally prevent them from purchasing coverage in the private market.

HIP *Health Insurance Program*—a program of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Hispanic or Latino/a An individual of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish

culture or origin, regardless of race.

HIV counseling and

testing

The delivery of HIV counseling to an individual. Counseling includes pretest and posttest counseling activities (e.g., offering the individual the HIV antibody test, as appropriate; services discussing the benefits of testing, including the medical benefits of diagnosing HIV disease in the early stages and of receiving early intervention primary care; reviewing the provisions of laws relating to confidentiality, including information regarding any disclosures that may be authorized under applicable law, and information regarding the availability of anonymous counseling and testing; and discussing the significance of the results, including the potential for developing HIV disease). Testing refers to antibody tests administered by health professionals to ascertain and confirm the presence of HIV infection (includes ELISA and Western Blot). Counseling and testing *does not* include tests to measure the extent of the deficiency in the immune system because these tests are fundamental components of comprehensive primary care. This service category also excludes mental health counseling/therapy, substance abuse counseling/treatment, and psychosocial support services. These services are listed separately. **HIV disease** Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

HIV/AIDS status The outcome of the client's HIV test result, which includes (1) HIV-positive not AIDS—client

has tested positive for and been diagnosed with HIV, but has not advanced to AIDS; (2) HIVpositive

AIDS status unknown—client has tested positive for and been diagnosed with HIV, but it is unknown whether or not the client has advanced to AIDS; (3) CDC-defined AIDS—client has advanced to and been diagnosed with CDC-defined AIDS; (4) HIV-negative (affected)—client is HIV-negative and is an affected individual of an HIV-positive partner or family member; and (5) unknown—HIV/AIDS status of the client is unknown and not documented. HIV/EIS HIV/Early Intervention Services/Primary Care—A program that encompasses the care supported by the Part C legislation and is made available by the grantee organization and its subcontractors. Subcontractors render care to clients referred to them by the grantee organization, and are reimbursed for their services, or otherwise have a remunerative relationship with the grantee for the referred service.

Home and

community-based

health services

Includes skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

Home health care The provision of services in the home by licensed health care workers such as nurses and the

administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

38 2007 Instructions for the Ryan White HIV/AIDS Program Data Report

Hospice services Includes room, board, nursing care, counseling, physician services, and palliative therapeutics

provided to clients in the terminal stages of illness in a residential setting, including a non-acutecare

section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Hospital or

university-based

clinic

Includes outpatient/ambulatory care/outpatient medical care departments or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance abuse treatment programs, STD clinics, AIDS clinics, and inpatient case management service programs.

Household All people who occupy a house, an apartment, a mobile home, a group of rooms, or a single

room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of unrelated people who share living arrangements.

Household income The sum of money received in the previous calendar year by all household members 15 years

old and over, including household members not related to the householder, people living alone, and others in non-family households.

Housing services The provision of short-term assistance to support emergency, temporary or transitional housing

to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

HRSA *Health Resources and Services Administration*—The U.S. Department of Health and Human

Services (DHHS) agency that is responsible for directing national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA is also responsible for administering the Ryan White HIV/AIDS Program. IDU *Injection drug user*—Individuals who report use of drugs intravenously or through skinpopping.

Inactive client A client whose status is inactive (as defined by your agency), which includes many possible

reasons (e.g., client moved or is lost to follow-up).

Indeterminate client A child under the age of 2 whose HIV status is not yet determined, but was born to an HIVinfected

mother.

Infected client An individual who is HIV-positive who receives at least one Ryan White HIV/AIDS Programeligible

service during the reporting period.

Inpatient setting This includes hospitals, emergency rooms and departments, and residential facilities where

clients typically receive food and lodging as well as treatments.

Institution This includes residential, health care, and correctional facilities. Residential facility includes

supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices.

Correctional facility includes jails, prisons, and correctional halfway houses.

Legal services The provision of services to individuals with respect to powers of attorney, do-not-resuscitate

orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistics services The provision of interpretation and translation services.

2007 Instructions for the Ryan White HIV/AIDS Program Data Report 39

Local county or State

health department

Publicly funded health department administered by a local, county, or State government.

LTBI Latent Treatment of Mycobacterium tuberculosis infection (LTBI) prevents the development of

active disease and has been an essential component of tuberculosis (TB) control in the United States for several decades.

MAI Minority AIDS Initiative—A national HHS initiative that provides special resources to reduce

the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. This initiative was enacted to address the disproportionate impact of the disease in such communities. It was formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

Medicaid A jointly funded, Federal-State health insurance program for certain low-income and needy

people.

Medical case

management

services (including

treatment adherence)

A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan;

(3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Medical nutrition

therapy

Provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical

transportation

services

Conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Medicare A health insurance program for people 65 years of age and older, some disabled people under

65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Mental health

services

Psychological and psychiatric treatment and counseling services, for individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Monotherapy The use of only one antiretroviral drug to reduce the amount of detectable HIV.

More than one race An individual who identifies with more than one racial category.

Mother with/at risk

for HIV infection

(perinatal

transmission)

Transmission of disease from mother to child during pregnancy.

MSM *Men who have sex with men*—Men who report sexual contact with other men (i.e., homosexual

contact) and men who report sexual contact with both men and women (i.e., bisexual contact). 40 2007 Instructions for the Ryan White HIV/AIDS Program Data Report

Native Hawaiian or

Other Pacific

Islander

An individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

New clients Individuals who received services from a provider for the first time ever during this reporting

period. Individuals who returned for care after an extended absence are not considered to be new unless past records of their care are not available.

Non-permanent Includes individuals who are homeless, as well as transient or in transitional housing. Homeless

includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for sleeping. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.

OI Opportunistic infection—An infection or cancer that occurs in individuals with weak immune systems due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus are all examples of opportunistic infections.

OMB Office of Management and Budget—The office within the executive branch of the Federal Government, which prepares the President's annual budget, develops the Federal Government's fiscal program, oversees administration of the budget, and reviews Government regulations.

Oral health care Includes diagnostic, preventive, and therapeutic services provided by general dental

practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Other communitybased

service

organization

Includes non-hospital-based organizations, AIDS service and volunteer organizations, private non-profit social service and mental health organizations, hospice programs (home and residential), home health care agencies, rehabilitation programs, substance abuse treatment programs, case management agencies, and mental health care providers.

Outpatient setting A hospital, clinic, medical office, or other place where clients receive health care services, but

do not stay overnight.

Outpatient/

ambulatory medical

care

Includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under** *Outpatient/ambulatory medical care***.**

Outreach services Programs that have as their principal purpose identification of people with unknown HIV

disease or those who know their status (i.e., case finding), so that they may become aware of, and may be enrolled in care and treatment services. Outreach services do not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Outside the EIS

program

A referral made to a provider that (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Part C grantee or its parent organization.

Part A The part of the Ryan White HIV/AIDS Program that provides direct financial assistance to designated EMAs/TGAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related: (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate,

from inpatient facilities.

Part B The part of the Ryan White HIV/AIDS Program that authorizes the distribution of Federal funds

to States and Territories to improve the quality, availability, and organization of health care and support services for individuals with HIV disease and their families. The Ryan White HIV/AIDS Program emphasizes that such care and support is part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated. The funds are distributed among States and Territories based, in part, on the number of AIDS cases in each State (or Territory) as a proportion of the number of AIDS cases reported in the entire United States.

Part C The part of the Ryan White HIV/AIDS Program that provides support for early intervention

services, including preventive, diagnostic, and therapeutic services for HIV/AIDS clients. This support includes a continuum of comprehensive primary health care, referrals for specialty care, counseling and testing, outreach, case management, and eligibility assistance.

Part D The part of the Ryan White HIV/AIDS Program that supports coordinated services for women,

infants, children, and youth with HIV disease and their affected family members. The Adolescent Initiative is a separate grant under the Part D program that is aimed at identifying adolescents who are HIV-positive and enrolling them in care.

Partner Notification A service provided by a clinician in your program to notify the partner of a client of possible

exposure to HIV. (Check State and local laws for specific requirements.) It is not the number of individuals who tested positive for HIV antibodies and offered partners' names for notification, nor is it the number of individuals who came to your program because of a referral by a partner notification service.

Pediatric developmental assessment and early intervention

services

The provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or a child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

42 2007 Instructions for the Ryan White HIV/AIDS Program Data Report

Permanency

planning

The provision of services to help clients/families make decisions about the placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Permanent housing Includes apartments, houses, foster homes, long-term residences, and boarding homes, as long

as they are not time limited.

PHSA Public Health Service Act.

Planning or evaluation

The systematic collection of information about the characteristics, activities, and outcomes of services or programs to assess the extent to which objectives have been achieved, needed improvements have been identified, and/or decisions about future programming have been made.

PLWHA coalition *People living with HIV/AIDS coalition*—Organizations of people living with HIV/AIDS that

provide support services to individuals and families infected with and/or affected by HIV and AIDS.

Primary health care

service

Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV-positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, medical case management, and pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; and counseling and testing.

Private health

insurance

Health insurance plans such as Blue Cross/Shield, Kaiser Permanente, Aetna, etc.

Private, for-profit

ownership

The organization is owned and operated by a private entity, even though the organization may receive government funding. A privately owned hospital is an example of a private, for-profit organization.

Private, nonprofit

(not faith-based)

The organization is owned and operated by a private, not-for-profit, non-religious-based entity, such as a non-profit health clinic.

Prophylaxis Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of

symptoms in an existing infection that has been brought under control (secondary prophylaxis).

Provider agency/

service provider

The agency that provides direct services to clients (and their families) and is funded by the Ryan White HIV/AIDS Program. Services may be funded through one or more Federal Ryan White HIV/AIDS Program grants, or through subcontract(s) with official Ryan White HIV/AIDS Program grantees. A provider may also be a grantee such as in Parts C and D.

Psychosocial

support services

The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Public/Federal

ownership

The organization is funded and operated by the Federal Government. An example is a Federal agency.

Public/local

ownership

The organization is funded and operated by a local government entity. An example is a city health department.

Public/State

ownership

The organization is funded and operated by a State government entity. An example is a State health department.

Publicly funded

community health

center

Includes community health centers, migrant health centers, rural health centers, and homeless health care centers.

Publicly funded

community mental

health center

A community-based agency, funded by local, state, or Federal funds, that provides mental health services to low income people.

2007 Instructions for the Ryan White HIV/AIDS Program Data Report 43

Quality management A systematic process with identified leadership, accountability, and dedicated resources that

uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change. The process is continuous and should fit within the framework of other program quality assurance and quality improvement activities, such as JCAHO and Medicaid. Data collected as part of this process should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized.

Referral for health

care/supportive

services

The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Referrals for health

services

The act of directing a client who is HIV-positive to a health service not available within an EIS program. For the purposes of Part C data reporting, the process of making a referral is independent of the health service provided, and does not require evidence that the client actually received the service for which he or she was referred. However, if the service that the client is being referred for is paid for by the EIS program, then the cost of providing referral services should be reported. Part C funds can be used to pay for the costs associated with making the referral, as well as to pay for the services for which the client was referred. The referrals reported by Part C programs should be referrals for health services provided outside of the EIS program. Case management and other referrals for social or support services should not be reported in the *Referrals* section, nor should they be factored into the cost of providing referral services. Examples of health services for which clients may be referred outside of the EIS program include primary health care or specialty health services, any diagnostic health services such as radiology, lab tests, mental health evaluations, biopsies, and so forth.

Rehabilitation

services

Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Reporting period A calendar year, January 1 through December 31 of the reporting year. The reporting period

may be shorter than a year if a provider agency did not receive Ryan White HIV/AIDS Program

funding for an entire calendar year.

Reporting scope Scope 01 is the reporting scope for providers reporting ELIGIBLE services. Under the

ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Parts A, B, C, and D funding are included in the report even if the service was not paid for with Ryan White Parts A, B, C, and D funds. This reporting scope is preferred by HRSA.

Code 02 is the reporting scope for providers reporting FUNDED clients. Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White A, B, C, and D funds are included in the report. Typically, this is a subset of the eligible reporting scope. Providers using the funded-only reporting scope must have an adequate mechanism for tracking clients and services by funding stream and have secured prior approval from their grantee in consultation with HRSA.

Respite care The provision of community or home-based, non-medical assistance designed to relieve

the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS. **Retrovirus** A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded

RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.

44 2007 Instructions for the Ryan White HIV/AIDS Program Data Report

Risk factor or risk

behavior/exposure

category

Behavior or other factor that places an individual at risk for disease. For HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work

Rvan White HIV/AIDS

Program

The Ryan White HIV/AIDS Treatment Modernization Act of 2006—The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWHA) disease and their families in the United States and its Territories. The newly enacted law changes how Ryan White funds can be used, with an emphasis on providing life-saving and lifeextending

services for people living with HIV/AIDS.

Section 330 of PHSA Supports the development and operation of community health centers that provide preventive

and primary health care services, supplemental health and support services, and environmental health services to medically underserved areas/populations.

Self-pay A client pays out of pocket for the majority of his or her health care costs.

Solo/group private

medical practice

Includes all health and health-related private non-profit practitioners and practice groups. **SPNS** *Special Projects of National Significance*—A health services demonstration, research, and evaluation program funded under Part F of the Ryan White HIV/AIDS Program. SPNS projects are awarded competitively.

STI Sexually transmitted infection—Infections spread by the transfer of organisms from person to person during sexual contact.

Substance abuse

services-residential

The provision of treatment to address substance abuse problems (including alcohol and/or legal

and illegal drugs) in a residential health service setting (short-term).

Substance abuse

services-outpatient

The provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Substance abuse

treatment center

An agency that focuses on the delivery of substance abuse treatment services.

Target population A population to be reached through some action or intervention; may refer to groups with

specific demographic or geographic characteristics.

Taxpayer ID # The unique nine-digit number issued to an organization or agency by the Internal Revenue

Service for use in connection with filing requirements. This may be the same as your Employer Identification Number (EIN).

TB skin test (PPD

Mantoux)

The abbreviation for purified protein derivative (PPD), a substance used in intradermal testing for tuberculosis.

Technical assistance

or TA

The identification of need for and delivery of practical program and technical support to the Ryan White HIV/AIDS Program community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating Ryan White HIV/AIDS Program supported planning and primary care service delivery systems.

Total client-months A calculation obtained by adding together the number of months that a premium, deductible, or

co-pay was made for each unduplicated client. (e.g., If an agency pays the premiums for Client A's insurance for 12 months and Client B's insurance for 8 months, the total client-months equals 20 months.)

Transgender An individual who exhibits the appearance and behavioral characteristics of the opposite sex.

Transmission

category

A grouping of disease exposure and infection routes. In relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact, perinatal transmission, etc.

2007 Instructions for the Ryan White HIV/AIDS Program Data Report 45

Treatment adherence

counseling

Provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

Unduplicated client

count

An accounting of clients in which a single individual is counted only once. For providers with multiple sites, a client is only counted once, even if he or she receives services at more than one of the providers' sites.

URN *Unique record number*—A nine-digit encrypted record number following HRSA's URN specifications that distinguishes the client from all other clients and that is the same for the client across all provider settings. The URN is constructed using the first letter of the first name,

the third letter of the first name (if blank use middle initial, if no middle initial use '9'), first letter of the last name, third letter of the last name (if blank, use '9'), month of birth, day of birth, and gender code. This string is then encrypted using a HRSA-supplied algorithm that can be incorporated into the provider's data collection system.

VA facility Any facility funded through the Veterans Administration.

Viral load test A test that measures the quantity of HIV RNA in the blood. Results are expressed as the number

of copies per milliliter of blood plasma. This test is employed as a predictor of disease progression.

White (not Hispanic) An individual having origins in any of the original peoples of Europe, the Middle East, or North

Africa, but not of Hispanic ethnicity.